MassachusettsDepartment of Public Health Determination of Need

Application Form

Version: 11-8-17

 Instructions

Application Type:Amendment

Application Date: 05/14/2021 11:42 am

Applicant Name:

Advocate Healthcare of East Boston

Mailing Address:

111 Orient Avenue

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: East Boston | State: |  | Massachusetts | Zip Code: | 02128 |
|  |  |  |  |  |  |
| Contact Person: Nina Edwards |  |  | Title: Attorney |  |  |
|  |  |  |  |  |  |
| Mailing Address: 4 Bayberry LaneCity: Framingham | State: |  | Massachusetts | Zip Code: | 01701 |

Phone:

6175849030

Ext:

E-mail:

|  |
| --- |
| **Facility Information****List each facility affected and or included in Proposed Project** |
| 1 Facility Name: Advocate Healthcare of East Boston Facility Address: 111 Orient AvenueCity: East Boston State: Massachusetts Zip Code: 02128Facility type: Long Term Care Facility CMS Number: 225413 Add additional Facility Delete this Facility  |
| **1. About the Applicant** |

* 1. Type of organization (of the Applicant):

for profit

* 1. Applicant's Business Type: Corporation  Limited Partnership  Partnership  Trust  LLC

 Other

* 1. What is the acronym used by the Applicant's Organization?
	2. Is Applicant aregisteredproviderorganization astheterm isusedintheHPC/CHIA RPOprogram?
	3. Is Applicant or any affiliated entity an HPC-certified ACO?
	4. Is Applicantorany affiliatethereofsubject toM.G.L. c.6D, §13and958CMR7.00(filingof Noticeof Material Change to the Health Policy Commission)?

 Yes  No

 Yes  No

Yes No

nina@bayberrylaw.com

* 1. Does the ProposedProject alsorequire thefilingof aMCNwith theHPC? Yes No
	2. Has theApplicant orany subsidiary thereof been notified pursuant toM.G.L. c. 12C, §16that it is exceedingthe health care cost growth benchmark established under M.G.L. c. 6D, § 9 and is thus, pursuant to M.G.L. c. 6D, §10 required to file a performance improvement plan with CHIA?

Yes No

**2. Project Description**

1.9 Complete the Affiliated Parties Form

2.1 Provide a brief description of the scope of the project.

The proposed amendment Is primarilyfocused onsecuringapproval for theincreasesin thecapitalcost. It does not seek to materially change the scopeof theapproved Project,however, certainadditionalbuildingrepairsand/or replacementsarerequested asrequired for HUD insured financing. The approved Project was for the restoration of twonursing units and related infrastructureof this aging, long term care facility. This request does not change that scope. The Project as approved and as continuesto be plannedincludes replacement and or repair of critical systems and fixed equipment, asbestos removal, and renovations addressing improved compliance with health care construction requirements for resident rooms and related service areas. It willresult in a reduction of beds from the current licensed capacity of 190 to 165. It will also result in the elimination of all rooms with three or four beds on the affected or renovated units. The Project will create an additional 7 single bed rooms.

2.2 and 2.3 Complete the Change in Service Form

# DelegatedReview

* 1. Do you assertthatthis Applicationiseligiblefor DelegatedReview?  Yes  No

3.1.a If yes, under what section?Conservation Projects

# Conservation Project

* 1. Are you submitting this Application as a Conservation Project?  Yes  No
	2. Within theProposed Project, is there any elementthat hastheresult of modernization, addition or expansion? Yes No
	3. Does theProposedProject addoraccommodateneworincreasedfunctionalitybeyondsustainment or restoration
	4. As part oftheProposedProject, is the Applicant:

Yes No

Adding a new service?

Modernizing the provision of a service?

Expandingaservice? Substituting a service?

Otherwise altering a serves's usage or designation, including patients served?

Adding a new piece(s) of equipment Modernizing a piece(s) of equipment?

Expanding bedcapacity? Adding bed capacity? Otherwisealtering bedcapacity,usage,ordesignation? Adding additional square footage?

# DoN-RequiredServicesandDoN-RequiredEquipment

* 1. Is this an application filed pursuant to 105 CMR 100.725: DoN-Required Equipment and DoN-Required Service? Yes  No

# Transferof Ownership

* 1. Is this an application filed pursuant to 105 CMR 100.735?  Yes  No

# AmbulatorySurgery

* 1. Is this an application filed pursuant to 105 CMR 100.740(A) for Ambulatory Surgery? Yes  No

# TransferofSite

* 1. Is this an application filed pursuant to 105 CMR 100.745? Yes  No

# Research Exemption

* 1. Is this an application for a Research Exemption?  Yes  No

# Amendment

* 1. Is this an application foraAmendment?  Yes  No
	2. This Amendment is:  Immaterial Change  Minor Change Significant Change
	3. Original Application number:

-19120215-CL

* + 1. Original Application Type:

Conservation Long Term Care Project

* + 1. Original Application filingdate:

12/04/2019

* + 1. Have there been any approved Amendmentstotheoriginal Application?

Yes No

**For Significant Amendment Changes:**

* + 1. Describe the proposed change.
		2. Describe the associatedcost implications to the Holder.
		3. Describe the associated cost implications to the Holder's existing Patient Panel.
		4. Provide a detailed narrative, comparingtheapproved projecttotheproposedSignificant Change,and therationalefor such change.

**The Holder hereby swears oraffirms that theabovestatementswithrespectto theproposed Significant Changeare True.**

Please see the attached narrative response

There should be minimal or nocost impactimplicationsfor theApplicant's existingPatient Panel. Any patient paidamountsare preset amounts not impacted bythe Applicant's costs. Private payratesmayexperiencelimitedincreases; however theApplicantaverages only about two percent (2%) of its residents who pay privately.

This amendment requests an increase in the approved maximum capital expenditure associated with the approved Project. The Applicant isisseekinganapproval foratotalcapitalexpenditureof$17,496,500.00. This isa73.4%increasefromthecurrentlyapproved

$10,087,722. Duetotheincreasedborrowingrequired,theApplicant willhave additionalinterest expense. There are noothermaterial changes projected inoperatingexpenses uponthecompletion of theproject andtherecontinues to exist thepotential forsavings from the variety of energy-related improvements in the Project.

This amendment is filedfor the purposeof requesting anincreasein the approved capital expenditure. The significant majority of the increase in capital expenditure relates totheincrease inProject costfrom thetimetheDoN wasdeveloped. The project scoperemains the renovations and improvements to twonursing units andthe Facility's aginginfrastructure; however, due to the requirements of HUD insured financing, certainadditionalcritical andnoncriticalrepairsare requiredthat were not includedintheoriginal DoN's Project scope. These itemsincludeoverhaul of thetwoelevators,replacementof boilers,removal of underground storage tan, facaderepairs, replacement of an electrical panel and other similar items as discussed in10.5.d.

# Emergency Application

* 1. Is this anapplicationfiledpursuantto105CMR100.740(B)? Yes No

|  |
| --- |
| **12. Total Value for Significant Amendments** |
| Enter all currency in numbers only. No dollar signs or commas. Grayed fields will auto calculate depending upon answers above.**Your project application is for a: Significant Amendment****Filing Fee: $0**12.1 Proposed increaseintotal value of thisproject: $7,408,778.00 |
| 12.2 Total increase in CHI commitment expressed in dollars: (calculated) $370,438.90 |
| 12.3 Total proposedConstructioncosts, specificallyrelatedtotheProposedProject, Ifany,whichwill be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated total dollars. |  |
|  |

Required Information and supporting documentation consistent with 105 CMR 100.210

Some Factors will not appeardepending upon the type of licenseyou areapplyingfor. Text fields will expand to fit your response.

**13. Factors**

**Documentation CheckList**

 Electronic copy of Staff Summary for Approved DoN

The Check List below will assist you in keeping track of additional documentation needed for your application.

Once you have completed this Application Form the additional documents needed for your application will be on this list. E-mail the documents as an attachment to: DPH.DON@state.ma.us

 Electronic copy of Original Decision Letter for Approved DoN Electronic Copy of any prior Amendments to the Approved DoN

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form.

To make changes tothe document un-check the "document is ready tofile" box. Edit document thenlock file andsubmit Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to Determination of Need" button.

**Thisdocumentisreadytofile:**

Date/time Stamp: 05/14/2021 11:42 am

E-mail submission to

Determination of Need

**Application Number: -21051411-AM**

**Use thisnumber on all communications regardingthis application.**

 Community Engagement-Self Assessment form